



**U.S. Immigration
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ICE Health Services Corps (IHSC)
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

Public Health Actions for the Management of Influenza

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Foreword

This *Public Health Actions for the Management of Influenza Guide* supplements the following IHSC Directives:

IHSC Directive: 05-06, *Infectious Disease Public Health Actions*

It replaces IHSC Directive 05-13, *Seasonal Influenza Management* and the accompanying Guide.

This Guide explains concepts, assigns responsibilities and details procedures for the prevention and control of influenza.

The intended audience is IHSC-staffed medical clinics supporting health care operations in ICE owned or contracted detention facilities.

I. Overview

A. Purpose

The purpose of this guide is to assist health staff to implement public health actions for the management of influenza in facilities with IHSC-staffed medical clinics. These activities must help to control and limit the spread of influenza.

B. Responsibilities

Health Services Administrator (HSA)

Ensure that health staff receives orientation and annual training related to public health actions for the management of influenza.

Ensure procedures are in place to comply with all policies and standards related to public health actions for the management of influenza.

Medical Providers

Oversee the clinical management of detainees/residents diagnosed with influenza.

Report cases of influenza to the health department in accordance with applicable local and state laws.

Health Staff

Implement infection prevention and control measures to prevent transmission of influenza in IHSC-staffed medical clinics in accordance with applicable guidelines.

Are knowledgeable about infection prevention and control measures applicable to work duties.

Notify the Safety, Infection Prevention, and Control Coordinator or designee to report cases of influenza to the health department in accordance with applicable local and state laws.

Clinic Safety, Infection Prevention and Control (SIPC) Coordinator

Reports cases of influenza to the health department in accordance with local and state laws.

Conducts contact and outbreak investigations and assists local health department, if applicable.

IHSC Headquarters (HQ) Public Health, Safety, and Preparedness Unit Staff

Provide technical guidance on activities related to public health actions for the management of influenza.

Review and update the IHSC Directive: 05-06, *IHSC Infectious Disease Public Health Actions* and the *Public Health Actions for the Management of Influenza in IHSC-Staffed Medical Clinics Guide*.

IHSC Infectious Disease Consultant

Provide technical guidance related to clinical management and public health actions for the management of influenza.

C. Acronyms

- ACIP** Advisory Committee on Immunization Practices
- CDC** Centers for Disease Control and Prevention
- IDSA** Infectious Diseases Society of America
- ILI** – Influenza-like illness
- PHSP** IHSC Public Health, Safety, and Preparedness Unit
- PPE** Personal Protective Equipment
- RIDTs** Rapid Influenza Diagnostic Tests
- SIPC** Safety, Infection Prevention, and Control

D. Definitions with Expanded Information

Airborne infection isolation (All) room A single-occupancy patient-care room; formerly called a negative pressure isolation room; environmental factors are controlled so the isolation room receives substantial air changes per hour (ACH) (≥ 12 ACH for new construction since 2001 and ≥ 6 ACH for construction before 2001) and is under negative pressure (the direction of air flow is from the outside adjacent space [the corridor] into the room); all room air is preferably exhausted to the outside, or recirculated if the return air is filtered through a high efficiency particulate air (HEPA) filter.

Cohorting Cohorting is a public health strategy used to house individuals separately as a group based on their infectious or exposure status.

Contagious – When a disease can be transmitted from one living being to another through direct or indirect contact; communicable; infectious; usually microorganisms.

Droplet Precautions Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in Appendix A and include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitides*, and group A streptococcus (for the first 24 hours of antimicrobial therapy). A single patient room is preferred for detainees/residents who require droplet precautions.

Epidemic – The occurrence of more cases of disease, injury, or other health condition than expected in a given area or among a specific group of persons during a particular period of time.

Exposure – The condition of being subjected to something (noise, dust, chemicals, radiation, infectious agents) that could have an adverse health effect.

Facility Staff – For IHSC purposes, this may refer to any non-medical staff at Service Processing Centers (SPCs), Contract Detention Facilities (CDFs), or Intergovernmental Service Agreement (IGSA) Facilities who are federal or contract employees. This includes, but is not limited to ERO Law Enforcement Officers and custody staff (contract or non-contract), who may or may not have contact with detainees. (IHSC Operational Definition)

Health Care Personnel or Providers – Health care personnel or providers are credentialed individuals employed, detailed, or authorized by IHSC to deliver health care services to detainees. It includes federal and contract staff assigned or detailed (i.e. temporary duty) who provide professional or paraprofessional health care services as part of their IHSC duties. (IHSC Operational Definition)

Health Staff – Health staff includes all health care professionals (including contracted staff) as well as administrative and supervisory staff at *IHSC staffed medical clinics*. (IHSC Operational Definition)

Influenza-like illness (ILI) Defined as fever (temperature of 100 F [37.8 C] or greater) and a cough or sore throat without a known cause other than influenza.

Incubation period – The interval between exposure to a communicable microorganism and onset of symptoms and/or infectiousness.

Infection control – Institutional procedures and policies for monitoring and attempting to control the transmission of communicable diseases.

Infectious period – The period during which a person can transmit a communicable microorganism to others.

Medical Providers – Medical providers include physicians, physician assistants, nurse practitioners, and clinical pharmacists. (IHSC Operational Definition)

Outbreak – The sudden increase in the incidence of a disease or condition, when the observed number of cases exceeds the expected number of cases of disease.

Standard Precautions – Infection prevention practices, including hand hygiene, that apply to all detainees/residents regardless of infectious status. Standard precautions are a combination and expansion of Universal Precautions and Body Substance Isolation, based on the principle that all blood, body fluids, secretions, non-intact skin, mucous membranes, and excretions (except sweat) contain transmissible infectious agents. Standard precautions includes hand hygiene, and depending on the anticipated exposure, use of gloves, gown, mask, eye protection, or face shield. Equipment or items in the patient environment likely to have been contaminated with infectious fluids must be handled in a manner to prevent transmission of infectious agents, (e.g., wear gloves for handling, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

Surgical Mask– A device worn over the nose and mouth of a person with suspected or confirmed infectious varicella to prevent infectious particles from being released into room air.

Symptomatic – A term applied to a patient with health-related complaints (symptoms) that might indicate the presence of disease.

Vaccine – A suspension containing antigenic molecules derived from a microorganism, given to stimulate an immune response to an infectious disease.

E. About Influenza

Influenza (the flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. There are two main types of influenza (flu) virus: Types A and B. The influenza A and B viruses that routinely spread in people (human influenza viruses) are responsible for seasonal flu epidemics each year. Influenza A viruses can

be broken down into sub-types depending on the genes that make up the surface proteins. Over the course of a flu season, different types and subtypes of influenza A and B viruses circulate and cause illness.

Serious outcomes of flu infection can result in hospitalization or death. Some people, such as older people, young children, and people with certain health conditions, are at high risk for serious flu complications.

Transmission

The influenza virus is spread by droplets made when people sneeze, cough, or talk. These droplets can land in a person's mouth or nose or can be inhaled into the respiratory tract. Transmission can also occur by touching contaminated surfaces or objects and then touching your own mouth or nose and through respiratory transmission when in close proximity of ill persons.

Incubation Period

It takes usually only one day after exposure for a person exposed to influenza to develop symptoms and to become contagious.

Infectious Period

A person can usually spread the virus from one day before symptoms develop and up to 5-7 days after becoming ill. Children may be contagious longer than seven days. Some may be infected with the influenza virus and have no symptoms but they may still spread the virus to others.

Seasonal Influenza Season

The flu season typically begins in October of each year and ends in late March; the peak month is February.

Symptoms

The influenza virus is different from a cold. The influenza virus usually comes on suddenly. People who have the influenza virus often feel some or all of these symptoms:

- Fever* or feeling feverish/chills

- Cough

- Sore throat

- Runny or stuffy nose

Muscle or body aches

Headaches

Fatigue (tiredness)

Some people may have vomiting and diarrhea, though this is more common in children than adults.

* It's important to note that not everyone with flu will have a fever.

Influenza-like illness (ILI) is defined as fever (temperature of 100 F [37.8 C] or greater) and a cough or sore throat without a known cause other than influenza.

Risk Factors for Flu-Related Complications

Most people who get influenza will recover in a few days to less than two weeks. Some people will develop complications as a result of the flu, some of which can be life-threatening and result in death.

Pneumonia, bronchitis, sinus and ear infections are examples of complications from flu. The flu can make chronic health problems worse. For example, people with asthma may experience asthma attacks while they have the flu, and people with chronic congestive heart failure may experience worsening of this condition that is triggered by the flu. People considered high risk for developing flu-related complications include the following:

Children younger than five, but especially children younger than two years old.

Adults 65 years of age and older.

Pregnant women.

American Indians and Alaskan Natives seem to be at higher risk of influenza complications.

People who have medical conditions, including the following:

Asthma.

Neurological and neurodevelopmental conditions [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability (mental

retardation), moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].

Chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis).

Heart disease (such as congenital heart disease, heart failure and coronary artery disease).

Blood disorders (such as sickle cell disease).

Chronic kidney disorders.

Chronic liver disorders.

Metabolic disorders (such as diabetes, inherited metabolic disorders and mitochondrial disorders).

Weakened immune system due to disease or medication (such as people with HIV or AIDS; cancer; autoimmune disease that can cause chronic inflammation of the joints and other areas of the body, including but not limited to rheumatoid arthritis and lupus; and those on chronic steroids or immunosuppressants).

People younger than 19 years of age who are receiving long-term aspirin therapy.

People who are morbidly obese (Body Mass Index [BMI] of 40 or greater).

Vaccination

Influenza vaccine is prioritized for administering to detainees/residents who are at high risk for complications and to control institutional outbreaks.

If supplies allow, medical providers may consider wide use of influenza vaccination for prevention or outbreak management.

Medical providers must consult [CDC - Prevention and Control of Seasonal Influenza with Vaccines | Health Professionals | Seasonal Influenza \(Flu\)](#) regarding persons for whom vaccination is contraindicated.

In the event of widespread circulation of novel influenza strains not covered by seasonal influenza vaccines, IHSC medical providers should consider immunizations for novel influenza strains for authorized use if and when they

become available and in accordance with [CDC - Prevention and Control of Seasonal Influenza with Vaccines | Health Professionals | Seasonal Influenza \(Flu\)](#).

Health care personnel must complete the Influenza Vaccination Screening Form in the medical record prior to administering the influenza vaccine.

Health care personnel must educate each detainee/resident using the current [Vaccine Information Statements \(VIS\)](#); translated VISs are available in several languages.

Health care personnel must document each influenza immunization administered in the detainee's/resident's electronic health record using the ADULT or PEDIATRIC IMMUNIZATION template and the IMMUNIZATIONS/THERAPEUTIC INJECTIONS tab.

Health care personnel must report adverse events that follow after influenza vaccination promptly to the [Vaccine Adverse Event Reporting System](#), even if the reporter is unsure whether vaccine caused the event. Reports may be filed securely online or by telephone at 1-800-822-7967 to request reporting forms or other assistance.

Additional Considerations for Family Residential Centers

Reference *OM 15-007 National Juvenile Immunization Protocol* and *OM 15-013 IHSC Immunization Protocol for ICE Family Residential Centers*

In addition to the groups at high risk for complications from influenza, the following groups should be prioritized for influenza vaccination:

- Housing contacts and caregivers of children younger than five years and adults aged 50 years and older, with particular emphasis on vaccinating contacts of children aged younger than six months; and
- Housing contacts and caregivers of people with medical conditions that put them at higher risk for severe complications from influenza.

II. Disease Management

A medical provider is responsible for the clinical management of detainees/residents diagnosed with influenza.

A. Diagnosis and Lab Testing

A medical provider should use influenza virus diagnostic testing when the results of such testing will:

- influence clinical care of the detainee/resident;

- influence clinical practice for other detainees/residents, such as detainees/residents at high risk for complications, and;

- influence outbreak control in a detention or residential facility.

A medical provider should consult [CDC - Clinical Description & Lab Diagnosis of Influenza | Health Professionals | Seasonal Influenza \(Flu\)](#) regarding considerations for influenza virus diagnostic testing and test interpretation.

Rapid Influenza Diagnostic Tests (RIDTs) may be used to help with diagnostic and treatment decisions. However, due to the limited sensitivities and predictive values of RIDTs, negative results of RIDTs do not exclude influenza virus infection in detainees/residents with signs and symptoms suggestive of influenza. Therefore, IHSC medical providers may evaluate whether antiviral treatment for detainees/residents with suspected influenza who are at high risk for complications is appropriate, even if the RIDT results are negative.

Testing is not needed for all detainees/residents with signs and symptoms of influenza to make antiviral treatment decisions. Once influenza activity has been documented in the community or geographic area, a clinical diagnosis of influenza can be made for detainees/residents with signs and symptoms consistent with suspected influenza, especially during periods of peak influenza activity in the community.

RIDTs can be useful to identify influenza virus infection as a cause of respiratory outbreaks in any setting, but especially in institutions. Positive RIDT results from one or more ill persons with suspected influenza can support decisions to promptly implement prevention and control measures for influenza outbreaks.

Testing respiratory specimens from several persons with suspected influenza will increase the likelihood of detecting influenza virus infection, if influenza virus is the cause of the outbreak.

Negative RIDT results may be followed by RT-PCR and/or viral culture to confirm or discount an outbreak due to influenza.

Health staff must coordinate with the clinic SIPC Coordinator or designee to notify public health authorities of any suspected institutional outbreak; collect respiratory specimens from ill persons (with positive or negative results by RIDT) and send them to a public health laboratory for more accurate influenza testing.

B. Treatment and Chemoprophylaxis

A medical provider should consider antiviral medications for the treatment and chemoprophylaxis of influenza in accordance with [CDC - Influenza Antiviral Medications: Summary for Clinicians | Health Professionals | Seasonal Influenza \(Flu\)](#) and [Seasonal Influenza in Adults and Children—Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management: Clinical Practice Guidelines of the Infectious Diseases Society of America](#), and with consideration of individuals at high risk for complications.

A medical provider should evaluate whether to treat detainees/residents with laboratory-confirmed influenza virus infection with an appropriate influenza antiviral medication.

A medical provider should evaluate whether to treat detainees/residents identified with ILI during suspected outbreaks with an influenza antiviral medication.

Health care personnel should obtain respiratory specimens from initial ill persons during institutional outbreaks and send them for testing to determine the virus type or subtype of influenza A virus associated with the outbreak to guide antiviral therapy decisions.

Where influenza outbreaks are suspected, antiviral medications most likely to be effective against the influenza virus that is the cause of the outbreak should be used, if known.

During outbreaks in a detention or residential facility, the IHSC medical provider should continue antiviral chemoprophylaxis for at risk detainees/residents for 14 days or for seven days after the onset of symptoms in the last person infected, whichever is longer.

III. Infection Prevention and Control

A. Standard and Droplet Precautions

Health staff must institute standard and droplet precautions for detainees/residents with influenza or ILI in accordance with [CDC - 2007 Isolation Precautions - HICPAC](#).

Health staff must maintain transmission-based precautions until the patient has been determined to be noncontagious. See also *IHSC Personal Protective Equipment Program Guide* and *IHSC Blood Borne Pathogen and Other Potentially Infectious Material Guide*).

For novel/epidemic strains and for which current vaccinations are inefficient, additional transmission-based precautions may be recommended to reduce transmission in the setting of vaccine inefficacy.

Health staff must implement standard cleaning disinfection guidelines in accordance with [CDC - 2008 Disinfection & Sterilization Guideline: HICPAC](#). Also see *IHSC Blood Borne Pathogen and Other Potentially Infectious Material Guide*).

B. Isolation Management for detainees/residents with influenza or ILI

When influenza or ILI is diagnosed in a detainee/resident, health staff must institute standard and droplet precautions and separate the ill detainee/resident from detainees/residents without influenza or ILI.

If possible, health care personnel must place detainees/residents with confirmed influenza or ILI in a single room or cell.

When a single room is not available, health care personnel should assess the medical risks and operational impact associated with other detainee/resident placement options, such as shared rooms with other detainee/resident with influenza or ILI.

During larger outbreaks, gender and classification separation must be maintained, and isolation capabilities may not be available. If isolation is not feasible, health care personnel should recommend that the beds of sick detainees/residents be placed at a distance of at least 6 feet from other detainees, to the extent possible.

If there is widespread flu transmission within a facility, isolation as a strategy may not be feasible.

An airborne infection isolation (AII) room is recommended when performing procedures that are more likely to generate higher concentrations of respiratory aerosols than coughing, sneezing, talking, or breathing.

Medical providers must send detainees/residents with suspected decompensation or complications to a hospital if medically necessary.

Health care personnel must perform temperature checks on detainees/residents with influenza or ILI at least once each day.

Health care personnel must educate detainees/residents about respiratory hygiene/cough etiquette strategies. Multilingual printable education materials can be located at [CDC - Cover Your Cough | Seasonal Influenza \(Flu\)](#).

If movement is required, health care personnel must recommend that the detainee/resident with influenza or ILI and exposed detainees/residents wear surgical masks (if tolerated).

Medical providers should evaluate whether to discontinue isolation of detainees/residents with seasonal influenza or ILI 24 hours after fever resolves or signs of fever without the use of fever-reducing medications.

IV. Outbreak and Exposure Management

Outbreak management follows [Seasonal Influenza in Adults and Children—Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management: Clinical Practice Guidelines of the Infectious Diseases Society of America](#). In the event of widespread circulation of novel and/or pandemic strains of influenza, more restrictive management measures may be implemented in accordance with Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control (CDC), and Infectious Diseases Society of America (IDSA) guidance and recommendations.

Health staff must coordinate with the clinic SIPC Coordinator to notify health departments of influenza diagnosis and outbreak investigations in accordance with local, state, and federal regulations.

Health staff must be familiar with the [ICE Pandemic Workforce Protection Plan](#).

A. Outbreak Management

Health staff must consider an influenza outbreak when two or more detainees/residents in the same facility with common exposures manifest

signs and symptoms of influenza-like-illness (ILI) within 72 hours of each other.

A medical provider should order testing for influenza of initial detainees/residents that are clinically ill to confirm and verify outbreak.

When influenza viruses are circulating in the facility, single positive laboratory results in conjunction with other compatible illnesses are suggestive of an institutional outbreak.

If influenza test results are positive despite antiviral chemoprophylaxis, the IHSC medical provider should consider the possibility of drug-resistant virus; the spread of influenza to previously unaffected areas of the facility where antiviral chemoprophylaxis had not been implemented, or multiple introductions of influenza from newly arriving detainees/residents.

if drug resistance is suspected, to consider submitting a respiratory sample to local health authorities for consideration of resistance testing.

Health staff must coordinate with the clinic SIPC Coordinator to notify the local or state health department of influenza outbreaks in accordance with local, state, and federal regulations.

Health staff must report influenza outbreaks to the IHSC Public Health, Safety, and Preparedness (PHSP) Unit promptly after lab confirmation is received using the outbreak and contact investigation reporting tool on SharePoint (when available).

Health staff must follow isolation management guidelines for detainees/residents with ILI or influenza as referenced above.

For more information on outbreak investigations reference the *IHSC Outbreak and Contact Investigation Guide*.

B. Cohorting of exposed detainees/residents

During outbreak management, health care personnel should evaluate whether to recommend cohorting with restricted movement to help reduce the spread of influenza. Strict cohorting may not be possible depending on facility characteristics, and lesser measures may be implemented to help decrease the likelihood of transmission.

If cohorting is recommended and feasible, health staff should recommend to facility staff to cohort all detainees/residents that were in close contact (within 6 feet) to the detainee/resident with ILI from 24 hours prior to symptom onset until four days following the latest exposure, and that new arrivals must not be introduced to a cohorted housing unit.

Health staff should advise facility staff to discontinue cohorting when all members of the cohort remain asymptomatic four days following the latest exposure.

If new ILI develops among detainees/residents in the cohort, health staff should advise facility staff to extend the cohorting period starting at day #1 and repeat the process until there is a full four day period without any new ILI.

A medical provider should consider antiviral prophylaxis according to ACIP, CDC, and IDSA recommendations.

Health care personnel must educate exposed detainees/residents to maintain awareness of ILI symptoms and the importance of seeking medical attention promptly should they develop symptoms consistent with ILI.

Cohorted and exposed detainees/residents should leave the cohort area only if absolutely necessary. Surgical mask should be worn when leaving the cohort area.

A medical provider should recommend to facility staff to avoid movement of cohorted detainees/residents within and between facilities until the incubation period has ended.

Following exposure to influenza, health care staff may identify cohorted detainees/residents scheduled for release/removal who are observed not to have signs/symptoms of ILI; if no signs or symptoms are found detainee/resident can be released.

V. Program Monitoring

PHSP Unit staff monitors influenza activity using the electronic health record reporting tools. PHSP Unit staff periodically request information from health staff at IHSC-staffed medical clinics for program monitoring.

VI. Training and Education

A. Health Staff

Training for public health actions for the management of influenza will be included in orientation and annual training requirements for all facility IHSC staff. Documentation of training completion will be entered into the personnel training record for each attendee and will include date of completion. Standardized national training materials including a content summary and version date will be centrally located and accessible by all IHSC staff.

The HSA or designee is responsible for compliance with training requirements and training documentation. The HSA may maintain a master training document for monitoring and reporting purposes; however, PII is not authorized on the master document.

B. Detainees/Residents

Health care personnel educate detainees/residents diagnosed with influenza about transmission, risk factors, and infection prevention and control. This education is documented in the detainee's/resident's electronic health record.

VII. Privacy and Recordkeeping

Health staff refers to IHSC Directive: 05-06, *Infectious Disease Public Health Actions* for guidance on complying with privacy and recordkeeping procedures.

VIII. References and Resources

1. [2011 Operations Manual ICE Performance-Based National Detention Standards \(PBNDS\)](#).
2. [ICE Family Residential Standards](#)
3. [American Correctional Association \(ACA\)](#).
4. [Correctional Health Care Standards | National Commission on Correctional Health Care](#).
5. [Centers for Disease Control and Prevention](#).
6. [CDC - Seasonal Influenza \(Flu\)](#).
7. [Health Alert Network | HAN Archive - 00359](#).
8. [CDC - Prevention and Control of Seasonal Influenza with Vaccines | Health Professionals | Seasonal Influenza \(Flu\)](#).
9. [CDC - Clinical Description & Lab Diagnosis of Influenza | Health Professionals | Seasonal Influenza \(Flu\)](#).

10. [CDC - Influenza Antiviral Medications: Summary for Clinicians | Health Professionals | Seasonal Influenza \(Flu\).](#)
11. [Seasonal Influenza in Adults and Children—Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management: Clinical Practice Guidelines of the Infectious Diseases Society of America.](#)
12. [CDC - 2007 Isolation Precautions - HICPAC.](#)
13. [CDC - 2008 Disinfection & Sterilization Guideline: HICPAC](#)
14. [CDC - Cover Your Cough | Seasonal Influenza \(Flu\)](#)
15. Review of the Use of Segregation for ICE Detainees, Policy No. 11065.1, September 4, 2013.